



HEALTH CENTER PROGRAM UPDATE

DATE: November 8, 2013

DOCUMENT TITLE: Look-Alike Renewal of Designation Application Instructions

TO: Health Center Program Look-Alikes
Primary Care Associations
Primary Care Organizations
National Cooperative Agreements

The Health Resources and Services Administration (HRSA) is committed to improving the health of underserved communities and vulnerable populations. Health Center Program look-alikes maintain a critical role in supporting the delivery of comprehensive, culturally competent, quality primary health care services to low-income, underserved, and special populations.

Enclosed are the revised renewal of designation application instructions. This document supersedes all previous renewal of designation instructions.

Application Submission Process: All look-alike applications must be submitted electronically via HRSA's Electronic Handbooks (EHB).

Effective Date: All applications begun in the HRSA EHB on or after January 1, 2014, are required to comply with the application instructions contained herein.

Designation Periods: The maximum project period length for all renewal of designation is three years. Look-alikes will receive a site visit to assess compliance at least once during each designation period.

Technical Assistance: HRSA is committed to providing technical assistance in the preparation of applications. Applicants who seek technical assistance in preparing a look-alike renewal of designation application may submit questions in writing to the organization's assigned Project Officer, State Primary Care Association (PCA) and/or Primary Care Office (PCO) for assistance in developing an application. Contact information for the State PCAs and PCOs are available on HRSA's Web site at <http://bphc.hrsa.gov/technicalassistance/>.

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Associate Administrator for Primary Health Care

Attachments

U.S. Department of Health and Human Services
Health Resources and Services Administration

Bureau of Primary Health Care

Health Center Program

Look-Alike Renewal of Designation Application Instructions

Release Date: November 8, 2013

All applications started in the HRSA Electronic Handbook (EHB) on or after the release date must adhere to the instructions contained herein.

Office of Policy and Program Development

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<http://bphc.hrsa.gov/about/lookalike/index.html>



Table of Contents

LOOK-ALIKE RENEWAL OF DESIGNATION PURPOSE AND BACKGROUND	6
Purpose	6
Terminology	6
Legislative Authority	6
HEALTH CENTER PROGRAM REQUIREMENTS	7
General Community Health Center (CHC) Requirements	7
Special Populations Requirements	7
Migrant Health Center Requirements	8
Health Care for the Homeless Requirements	8
Public Housing Primary Care Requirements	8
ELIGIBILITY	8
APPLICATION REQUIREMENTS	10
PROJECT ABSTRACT	11
PROGRAM NARRATIVE REQUIREMENTS	11
Need	12
Response	12
Collaboration	16
Evaluative Measures	17
Resources/Capabilities	17
Governance	19
REQUIRED FORMS, DOCUMENTS, AND ATTACHMENTS	21
Required Forms and Documents	21
Required Attachments	24
SUBMITTING THE APPLICATION	25
ADDITIONAL INFORMATION AND TECHNICAL ASSISTANCE	26
Program Requirements and Application Questions	26
Navigating and Completing Applications in the EHB	26

APPENDIX A: REQUIRED FORMS INSTRUCTIONS	27
FORM 1A – General Information Worksheet (Required)	27
FORM 2 – Staffing Profile (Required)	28
FORM 3 – Income Analysis (Required)	29
FORM 3A – Look-Alike Budget Information (Required)	32
FORM 4 – Community Characteristics (Required)	32
FORM 5A – Services Provided (Required)	34
FORM 5B – Service Sites (Required)	34
FORM 5C – Other Activities/Location (As applicable)	34
FORM 6A – Current Board Member Characteristics (Required)	34
FORM 8 – Health Center Agreements (Required)	35
FORM 9 – Need for Assistance Worksheet (NFA) (Required)	36
Form 10 – Annual Emergency Preparedness Report (Required)	42
Form 12 – Organizational Contacts (Required)	42
APPENDIX B: CLINICAL AND FINANCIAL PERFORMANCE MEASURES INSTRUCTIONS	43
Performance Measures	43
Need Addressed/Focus Area	44
Designation Period Goal(s) with Baseline	44
Performance Measure(s)	45
Data Source & Methodology	45
Key Factors	45
Major Planned Actions	45
Comments/Notes	45
APPENDIX C: REQUIRED ATTACHMENTS INSTRUCTIONS	49
Attachment 1—Service Area Map (Required)	49
Attachment 2— Current MUA/MUP Designation (Required)	49
Attachment 3—Governing Board Bylaws (Required)	50
Attachment 4—Co-Applicant Agreement for Public Centers (As applicable)	50

Attachment 5—Affiliation, Contract, and/or Referral Agreements (As applicable)	50
Attachment 6—Articles of Incorporation (Required)	51
Attachment 7—Evidence of Non-Profit or Public Agency Status (Required)	51
Attachment 8—Medicare and Medicaid Provider Documentation (Required)	52
Attachment 9—Organizational Chart (Required)	52
Attachment 10—Position Descriptions for Key Personnel (Required)	52
Attachment 11—Resumes for Key Personnel (Required)	53
Attachment 12—Schedule of Discounts/Sliding Fee Scale (Required)	53
Attachment 13—Most Recent Independent Financial Audit (Required)	53
Attachment 14—Letters of Support (Required)	53
Attachment 15—Floor Plans (As applicable)	53
Attachment 16—Budget Narrative (Required)	53
Attachment 17—Other Information (As applicable)	54

LOOK-ALIKE RENEWAL OF DESIGNATION PURPOSE AND BACKGROUND

Purpose

The Health Resources and Services Administration (HRSA) administers the Health Center Program.¹ Health centers, which include both grantees and look-alikes, improve the health of the Nation's underserved communities and vulnerable populations by ensuring access to comprehensive, culturally competent, quality primary health care services. Individually, each health center plays an important role in ensuring access to services, and when combined, they have had a critical impact on the health care status of medically underserved and vulnerable populations throughout the United States and its territories.

Terminology

Historically, look-alikes have been referred to as Federally Qualified Health Center (FQHC) Look-Alikes. This document uses the term "look-alikes" to underscore: (1) that Health Center Program look-alikes are health centers that "look like" Health Center Program grantees that do not receive a grant under section 330 of the PHS Act; and (2) that look-alikes are eligible, as are Health Center Program grantees, to apply to CMS for reimbursement under Medicare and Medicaid FQHC payment methodologies.

Legislative Authority

An amendment to the Omnibus Budget Reconciliation Acts² created and defined a category of facilities under Medicare and Medicaid known as FQHCs. One of the definitions of an FQHC as set forth³ is an entity determined by the delegated Department of Health and Human Services (HHS) authority to meet the requirements of the grant program authorized by section 330 of the PHS Act (the Health Center Program, 42 U.S.C. 254b), but does not receive a Health Center Program grant. This category of health centers has been labeled, "look-alikes."

The Balanced Budget Act of 1997⁴ modified the look-alike definition under section 1905 of the SSA by adding the requirement that the "entity may not be owned, controlled or operated by another entity." HRSA, in collaboration with the CMS, issued Policy Information Notice (PIN) 1999-09, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities, issued April 20, 1999, and PIN 1999-10, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Nonprofit Entities, issued April 20, 1999, to implement the BBA requirements for public agencies and private nonprofit organizations. These documents describe the statutory limits on the involvement of another entity in the ownership, control, and/or operation of a public or private nonprofit look-alike.

¹ Authorized by section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b).

² Omnibus Budget Reconciliation Acts (OBRA) of 1989, 1990, and 1993, amended section 1905 of the Social Security Act (SSA).

³ Section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the SSA.

⁴ Public Law 105-33.

Applicants should work closely with HRSA if there are questions about the application of these policies before submitting a renewal of designation application.

Health Center Program Requirements

Look-alikes must demonstrate compliance with the applicable requirements of section 330 of the PHS Act, 42 Code of Federal Regulations (CFR) Part 51c (Grants for Community Health Centers),⁵ and 42 CFR Part 56 (Grants for Migrant Health Services and Migrant Health Centers),⁶ referred to also as Health Center Program requirements, as applicable. HRSA encourages applicants to review the Health Center Program requirements and applicable statutes, regulations, and policies prior to developing an application. These are available on HRSA's website at <http://www.bphc.hrsa.gov/about/requirements/index.html>. All health centers must ensure the availability and accessibility of required primary health care, as well as preventive, and enabling services, including oral health, mental health, and substance abuse services, regardless of an individual's ability to pay.

General Community Health Center (CHC) Requirements

Applicants that serve the general medically underserved population must demonstrate compliance with section 330(e)(Community Health Center) statutory and regulatory program requirements and applicable policies. Applicants must ensure services are available to all residents of the service area (including migratory and seasonal agricultural workers, persons experiencing homelessness, and residents of public housing), to the extent possible using available resources.⁷ Requirements include:

- Compliance with general community Health Center Program requirements; and
- A plan that ensures the availability and accessibility of required primary and preventive health care services, including oral health, mental health, and substance abuse services, to all individuals in the service area.

Special Populations Requirements

Applicants that exclusively serve a special population(s) are not subject to the requirement to provide access to care for all residents of the service area; however, all health centers must address the acute care needs of all who present for service regardless of residence and/or ability to pay. Applicants serving only a special population(s) may request a "good cause" exemption to waive the requirement that the center provide all required primary health services.⁸ HRSA will only consider waiver of the 51 percent consumer/patient majority governance requirement.

⁵ 42 CFR Part 51c does not apply to look-alikes exclusively serving homeless individuals or residents of public housing.

⁶ 42 CFR Part 56 only applies to look-alikes exclusively serving migratory and seasonal agricultural workers.

⁷ Section 330(a)(1)(B) of the PHS Act.

⁸ Section 330(k)(3)(H)(iii) of the PHS Act.

Migrant Health Center Requirements

- Compliance with Migrant Health Center and, as applicable, general community program requirements;⁹ and
- A plan that ensures: (1) the availability and accessibility of required primary and preventive health services, including oral health, mental health and substance abuse services, to migratory and seasonal agricultural workers and their families in the area to be served; (2) how adjustments will be made for service delivery during peak and off-season cycles; and (3) how the special environmental and occupational health concerns will be addressed.

Health Care for the Homeless Requirements

- Compliance with Health Care for the Homeless and, as applicable, general community program requirements;¹⁰
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health, and substance abuse services, to people experiencing homelessness in the area to be served; and
- A mechanism for delivering comprehensive substance abuse services to homeless patients (i.e., detoxification, risk reduction, outpatient treatment, residential treatment, and rehabilitation for substance abuse provided in settings other than hospitals).

Public Housing Primary Care Requirements

- Compliance with Public Housing Primary Care and, as applicable, general community program requirements;¹¹
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health, and substance abuse services, to residents of public housing primary care in the area to be served; and
- A mechanism for involving residents in the preparation of the application and in the ongoing planning and administration of the program.

HRSA will not grant waivers for organizations that serve the general population or the general population in conjunction with a special population.

ELIGIBILITY

A renewal of designation application must meet all of the applicable eligibility requirements listed below. Applications that do not meet the eligibility requirements will be considered non-responsive and will not be considered for renewal of designation.

⁹ PHS Act section 330(g) and 330(e) and program regulations.

¹⁰ PHS Act section 330(h) and 330(e) and program regulations.

¹¹ PHS Act section 330(i) and 330(e) and program regulations.

- Applicant is a public or private, nonprofit entity, including tribal, faith-based, and community-based organization.
- Application serves a defined geographic area that is currently federally designated, in whole or in part, as a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP).^{12, 13, 14}

NOTE: Applicants with designation only for special populations are not required to have an MUA/MUP designation for the service area and/or target population.

- Applicant is independently owned, controlled, and operated¹⁵ per section 1905(l)(2)(B) of the SSA.

Additional policy clarification regarding health center affiliations is available in Policy Information Notice 1998-24: Amendment to PIN 1997-27, Regarding Affiliation Agreements of Community and Migrant Health Centers located at <http://bphc.hrsa.gov/policiesregulations/policies/pin199824.html>. In addition, HRSA's interpretation of the statutory limits on the involvement of another entity in the ownership, control and/or operation of a public entity or private nonprofit entity is located in PINs 1999-09 and 1999-10, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities and for Private Nonprofit Entities, respectively, provide additional information. These PINS are located at <http://bphc.hrsa.gov/policiesregulations/policies/index.html>.

NOTE: Applicants with a corporate integration model may be subject to a review by the Department's Office of the General Counsel against State law reserved authorities.

- Applicant provides comprehensive primary medical care as its primary purpose. All required services must be provided with contracts and written formal referral arrangements in place for any services not provided directly by the applicant.
- Applicant requests renewal of designation for at least one permanent service delivery site that provides access to all required comprehensive primary, preventive, enabling, and additional

¹² Look-alike applicants do not have to be located in a MUA but must serve in whole or in part either an MUA or MUP.

¹³ Requested, not required for look-alikes exclusively serving migratory and seasonal agricultural workers, homeless individuals, or residents of public housing.

¹⁴ The list of MUAs and MUPs is available at <http://bhpr.hrsa.gov/shortage/>.

¹⁵ See PIN 1999-09, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities (dated April 20, 1999) at <http://www.bphc.hrsa.gov/policiesregulations/policies/pin199909.html>, PIN 1999-10, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Non-Profit Entities (dated April 20, 1999) at <http://www.bphc.hrsa.gov/policiesregulations/policies/pin199910.html>.

health care services including oral health care, mental health care, and substance abuse services, either directly on-site or through established written arrangements without regard to ability to pay.¹⁶

- Applicant proposes to serve all individuals in the targeted service area or population to the extent possible using available resources. Applicants cannot propose to exclusively serve a single age group (e.g., children) or health issue/disease category (e.g., HIV/AIDS, chronically mentally ill). If an applicant proposes to target a sub-population within the service area or population (e.g., children in schools or adults with chronic mental illness), the applicant must demonstrate how all required health care services will be made available to those and other persons in need of care who may seek services at the look-alike site(s).

APPLICATION REQUIREMENTS

HRSA strongly encourages applicants to work with the appropriate Primary Care Associations, Primary Care Offices, and/or National Cooperative Agreements in developing a look-alike renewal of designation application and throughout the application process. Refer to <http://www.bphc.hrsa.gov/technicalassistance/> for a complete listing of these organizations.

All successful renewal of designation applications must:

1. Demonstrate that the applicant is providing all required services in compliance with Health Center Program requirements at the time of application.¹⁷
2. Display responsiveness to the health care environment of the service area and demonstrate collaborative and coordinated delivery systems for the provision of primary health care to the underserved.
3. Demonstrate that the look-alike is currently providing and will continue to provide access to comprehensive, culturally competent, quality primary health care services as its primary purpose to improve the health status of underserved and vulnerable populations in the service area.
4. Demonstrate a high level of primary health care need in the community/population served. Applicants must submit a completed Form 9—Need for Assistance (NFA) Worksheet to demonstrate the relative need for additional primary health care services.
5. Provide evidence of how the look-alike project will maintain or increase access to primary health care services, improve health outcomes and reduce health disparities in the community/population to be served.
6. Demonstrate responsiveness to the health care environment and the underserved in their community by documenting the organization's collaborative and coordinated health care delivery systems. Applicants must demonstrate partnerships and collaborative activities with Health Center Program look-alikes and grantees, rural health clinics, hospitals, State and local health departments, and/or health services delivery projects and other programs serving the

¹⁶ Migrant Health Center applicants may be seasonally operated.

¹⁷ Program requirements are available at <http://www.bphc.hrsa.gov/about/requirements/index.html>.

same population(s). Discuss changes in insurance coverage, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP), including changes that could result from the Affordable Care Act implementation.

7. Provide a sound and complete plan that reflects appropriate short- and long-term strategic planning and coordination with other providers of care, organizational capability to manage the scope of project, and cost-effectiveness in addressing the health care needs of the target population.
8. Provide a reasonable and accurate budget (Form 3A–Look-Alike Budget) based on the approved scope of project.

PROJECT ABSTRACT

The project abstract should be single-spaced, one-page summary of the application. It will be uploaded to the Electronic Handbooks (EHB). The abstract should be clear, accurate, concise, and without reference to other parts of the application. The abstract must include a brief description of the project, including the applicant organization, target population, needs to be addressed, and services. It must address:

1. A brief history of the organization, the community to be served, and the target population;
2. A summary of the major health care needs and barriers to care to be addressed by the project, including the needs of special populations (migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing);
3. How the project will address the need for comprehensive primary health care services in the community and target population; and
4. The number of current and patients, visits, providers, service delivery sites and locations, and services to be provided.

PROGRAM NARRATIVE REQUIREMENTS

The Program Narrative provides a comprehensive description of the look-alike project. It should provide a detailed picture of the community/target population served, the organizational structure, and how the organization is addressing the identified primary health care needs of the community.

Applicants must fully address all requirements within the narrative component of the application. All documents (i.e., Program Narrative, forms, documents, and attachments) are evaluated individually and collectively for consistency. The Program Narrative should be succinct, self-explanatory, and well-organized. Applicants must respond to all criteria and submit all applicable forms and attachments to demonstrate compliance with program requirements located at <http://www.bphc.hrsa.gov/about/requirements/index.html>. HRSA may disapprove applications that do not include all required information.

The Program Narrative should be organized using the following framework and section headers. Applicants must ensure that all of the specific elements in the Program Narrative are completely addressed.

Applicants should label each section of the Program Narrative (Need, Response, Collaboration, Evaluative Measures) and label each sub-section (e.g., “Target Population”) as outlined below.

Need

Information provided on need should serve as the basis for, and align with, the activities and goals described in the Clinical and Financial Performance Measures Forms and throughout the application.

1. **Target Population.** Describe the unique characteristics of the target population, including characteristics that impact access to primary health care, health care utilization, and/or health status. Describe additional aspects of need that are not captured by quantitative data. Reference Form 4—Community Characteristics and Form 9—Need for Assistance.
2. **Existing Services.** Describe existing health care services (including mental health/substance abuse and oral health) currently available in the applicant’s service area, including any gaps in services (e.g., provider shortages) and the role and location of any other providers who currently serve the target population. Reference data from the UDS Mapper and Attachment 1—Service Area Map.
3. **Health Care Environment.** Describe the health care environment and any significant changes that have affected the community’s ability to provide services and/or have affected the applicant’s fiscal stability, if applicable. Reference Form 3—Income Analysis Form, Form 3A—Look-Alike Budget Information and Attachment 13—Most Recent Independent Financial Audit, as applicable.
4. **Special Populations.** For applicants with designation to serve migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing, describe the specific health care needs and access issues of the special population(s).

Response

1. **Service Delivery Model.** Describe the service delivery model(s) to serve the health care needs identified in the Need section, including service delivery models to meet the specific needs of special populations if the organization has a special population designation. The applicant must clearly demonstrate how the primary purpose of the organization is the provision of primary medical care. All sites and activities described should be consistent with those listed in Forms 5B—Service Sites and 5C—Other Activities/Locations, including locations of sites, hours, and after-hours care. The service delivery model must be supported by information provided in Form 1A—General Information Worksheet, Form 2—Staffing Profile, Form 5A—Services Provided and Attachment 11—Resumes for Key Personnel.

NOTE: Only Public Housing Primary Care applicants must demonstrate that the service site(s) is (are) immediately accessible to the public housing community being targeted.

2. **Primary Health Care Services.** Describe how each required primary health care service is provided and discuss how the services provided are appropriate for the needs of the target population and are available and accessible to all life cycles without regard to ability to pay.

Describe the hours of operation, including any evening and/or weekend hours. Services discussed should be consistent with those listed in Form 5A—Services Provided, and applicants should reference the form as applicable.

NOTE: Required primary health care services must be provided directly by the health center or through an established written arrangement, such as through a contract/formal agreement or through a formal written referral arrangement. In addition, required services provided directly by the look-alike or by formal agreements or formal written referral arrangements must be offered on a sliding fee scale and available equally to all patients regardless of ability to pay. Informal referral arrangements are not acceptable for the provision of a required service.

NOTE: Only Health Care for the Homeless applicants must demonstrate that substance abuse services will be made available as part of the required services.

3. **Enabling Services.** Describe how the service delivery model(s) ensures the integration of enabling services (e.g., case management, outreach, transportation) into the primary health care delivery system.
4. **Continuity of Care.** Describe how the organization ensures continuity of care, access to a continuum of care, and access to specialty care services. The description must address:
 - a. Continuity of care, including arrangements for admitting privileges for health center physicians at one or more hospitals (consistent with Form 5C). In cases where hospital privileges are not possible, describe other arrangements to ensure continuity of care.
 - b. A seamless continuum of care, including discharge planning, post-hospitalization tracking, patient tracking (e.g., shared electronic health records), and referral relationships for specialty care (including relationships with one or more hospitals), with an emphasis on working collaboratively to meet local needs.
5. **Contracts/Formal Written Agreements.**
 - a. **Contracts for a Substantial Scope of Project.** Discuss the appropriateness of all current contracts for a substantial portion of the operation of the health center. Contracts for a substantial portion of the scope of project include any of the following:
 - i. Core primary care providers (consistent with Health Center Program requirements);¹⁸
 - ii. Non-provider health center staff;
 - iii. Chief medical officer (CMO);
 - iv. Chief financial officer (CFO); and/or
 - v. A memorandum of understanding (MOU) or memorandum of agreement (MOA) for a substantial portion of the scope of project.

¹⁸ Health Center Staffing Requirement: Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged. (Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act).

Complete contracts for a substantial portion of the operation of the health center must be included on Form 8—Health Center Agreements and attached in full according to the instructions provided in Form 8.

NOTE: All applicants must complete Form 8—Health Center Agreements and reference it throughout the Response section as applicable. In addition, CHC and/or MHC applicants that respond “no” to any question in the Governance checklist section of Form 8 must clearly discuss the specific situation(s).

- b. **Other contracts.** Discuss the appropriateness of other contracts/formal written agreements. All contracts/formal written agreements (including those constituting a substantial scope of project) and formal written referral arrangements (see below) must be summarized in Attachment 5—Affiliation, Contract, and/or Referral Agreements.
6. **Clinical Staffing.** Describe the clinical team staffing plan (consistent with Form 2), including the mix of provider types and support staff necessary for:
- a. Providing services for the projected number of patients (consistent with Form 1A).
 - b. Assuring appropriate linguistic and cultural competence (e.g., bilingual/multicultural staff, training opportunities).

NOTE: Contracted providers should not be included on the clinical team staffing plan (Form 2). Such providers should be included on the summary of current or contracts/agreements in Attachment 7.

NOTE: The applicant must include a summary of all current contracts in Attachment 5—Affiliation, Contract, and/or Referral Agreements and complete copies of contracts in Form 8—Health Center Agreements for contracts that constitute a substantial scope of project, i.e., core primary care providers.

- c. **Formal Written Referral Arrangements.** Under a formal written referral arrangement, the applicant maintains responsibility for the patient’s treatment plan and will be providing and/or paying/billing for appropriate follow-up care based on the outcome of the referral.

Describe how formal written referral arrangements are utilized to provide required, preventive, enabling, and additional health services as appropriate and necessary. Discuss how visits will be documented in the patient record, how follow-up care will be ensured, and how services will be provided on a sliding fee discount scale compliant with Health Center Program requirements. These arrangements must align with services indicated in Form 5A—Services Provided, Column III and must be summarized in Attachment 5—Affiliation, Contract, and/or Referral Agreements.

NOTE: Informal referral arrangements are not acceptable for the provision of required services.

7. **Patient Discounts.** Describe the system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay and demonstrate how the established schedule of charges is consistent with locally prevailing rates or charges. In addition, describe how the corresponding schedule of discounts/sliding fee scale ensures that no patient will be denied services due to their inability to pay. Reference the schedule of discounts/sliding fee scale in Attachment 12—Schedule of Discounts in the response.

NOTE: Ability to pay is determined by a patient's annual income and family size according to the most recent Federal Poverty Guidelines for the contiguous 48 states, Alaska and Hawaii. Additional information is available on HHS' website at <http://aspe.hhs.gov/poverty/>.

8. **Quality Improvement/Quality Assurance (QI/QA).** Describe the organization's quality improvement/quality assurance (QI/QA) and risk management plan(s) including:
- Accountability and communication throughout the organization for systematically improving the provision of quality health care, including a clinical director whose responsibilities clearly include oversight of the QI/QA program.
 - The process and parties responsible for developing, getting board approval and updating policies and procedures that support the QI/QA and risk management plan(s).
 - The process and parties responsible for provider licensure, credentials, and privileges – ensuring that all providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform services (consistent with Form 5A) at sites/locations (consistent with Forms 5B and 5C).
 - Risk management procedures, including those related to patient grievance procedures and incident reporting and management.
 - Monitoring the impact of the provision and efficiency of clinical services on the assessed health needs of the target population (e.g., clinical and financial performance measures).
 - Maintenance of confidentiality of patient records throughout the continuum of care.
 - Periodic assessment of appropriateness of service utilization, quality of services delivered, and patient outcomes, conducted by physicians or other licensed health professionals under the supervision of physician, including peer review and systematic evaluation of patient records to identify areas for improvement in documentation of services provided either directly or through referral.
 - Utilization of appropriate information systems for tracking, analyzing, and reporting key performance data, including data necessary for 1) required performance measures (e.g., electronic health records, payment management systems) and 2) tracking of diagnostic tests and other services provided to health center patients to ensure appropriate follow up and documentation in patient record.
 - Utilization of QI results to improve performance.

NOTE: Clinical directors may be full or part-time staff and should have appropriate credentials (e.g., MD, NP, PA, MPH) to support the QI/QA plan as determined by needs and size of the health center.

9. **Eligibility and Enrollment.** Describe how the organization will assist individuals in determining their eligibility for, and enrollment in, health insurance options that will be available starting in

January 2014 as a result of the Affordable Care Act (e.g., Medicaid coverage for individual up to 133 percent of the Federal poverty guidelines (FPG) in states choosing to provide this coverage; the ability to purchase insurance through an Exchange; the availability of Advanced Premium Tax Credits for insurance purchased through and Exchange for individuals with incomes up to 400 percent FPG; and the availability of cost-sharing reductions for insurance purchase through an Exchange for persons up to 250 percent of the Federal poverty guidelines). Specifically describe how potentially-eligible individuals will be identified and informed of the new options; what type of assistance will be provided for determining eligibility; and what type of assistance will be provided to complete of the relevant enrollment process.

Collaboration

1. **Other Health Centers in Service Area.** List all other Health Center Program grantees and look-alikes in or adjacent to the service area (see HRSA's UDS Mapper, located at <http://www.udsmapper.org/>). Describe formal and informal collaboration and coordination of services¹⁹ with each of these entities.
2. **Other Safety Net Providers in Service Area.** Describe formal and informal collaboration and coordination of services²⁰ with other health care providers in the service area, including rural health clinics, hospitals, State and local health departments and/or health care delivery projects, private providers and programs serving the same population(s). Include letters of support from these entities in Attachment 14—Letters of Support.
3. **Special Populations Applicants.** Migrant Health Center, Health Care for the Homeless, and/or Public Housing Primary Care applicants must discuss formal agreements with other organizations that provide services or support to the special population(s) for which designation is sought.

NOTE: Formal collaboration (contracts, agreements, and/or arrangements) should also be summarized in Attachment 5—Affiliation, Contract, and/or Referral Agreements.

NOTE: Applicants MUST document support for the look-alike renewal of designation through current dated letters of support from all Health Center Program grantees and look-alikes, health departments, rural health clinics, and/or hospitals in the service area. If such letters cannot be obtained, include documentation of efforts made to obtain the letters along with an explanation including documentation of efforts made to obtain the letter. All letters of support should be merged into one document, included in Attachment 14, and referenced in the application as appropriate.

¹⁹ Review PAL 2011-02, Health Center Collaboration available at <http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html> for information on maximizing opportunities to collaborate with other health care safety net providers.

²⁰ Review PAL 2011-02, Health Center Collaboration available at <http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html> for information on maximizing opportunities to collaborate with other health care safety net providers.

Evaluative Measures

Information provided on need should serve as the basis for, and align with, the activities and goals described in the clinical and financial performance measures and throughout the application. The applicant must demonstrate that its program data reporting systems accurately collect and organize data for reporting and support management decision-making.

1. **Clinical Performance Measures.** Outline within the Clinical Performance Measures Form, current baselines and time-framed and realistic goals that are responsive to the health needs identified in the application. See detailed instructions in Appendix B: Clinical and Financial Performance Measures Instructions.
2. **Financial Performance Measures.** Outline within the Financial Performance Measures Form, current baselines and time-framed and realistic goals that are responsive to the strategic planning needs identified in the application. See detailed instructions in Appendix B: Clinical and Financial Performance Measures Instructions.
3. **Additional Measures.** Provide a brief description of any additional evaluation activities planned to assess progress throughout the designation period, including tools used to collect and analyze relevant data.

Resources/Capabilities

1. **Organizational Structure.** Describe how the organizational structure is appropriate for the operational needs of the project, including how lines of authority are maintained from the governing board to the chief executive officer (CEO)/executive director down through the management structure and are in accordance with Health Center Program requirements. Reference Attachment 3—Governing Board Bylaws, Attachment 9—Organizational Chart, and, as applicable: Attachment 4—Co-Applicant Agreement for Public Centers (for Public Centers that have a co-applicant board),²¹ and Attachment 5—Affiliation, Contract, and/or Referral Agreements.
2. **Oversight of Contracted Services.** Describe how the organization maintains appropriate oversight and authority over all contracted services, including any affiliation arrangement(s) (as referenced in Program Specific Form 8—Health Center Agreements), in accordance with Health Center Program requirements.²² Applicants must summarize all applicable current or contracts and/or other agreements in Attachment 5—Affiliation, Contract, and/or Referral Agreements. If

²¹ In cases where a public center has a co-applicant board, the public center and co-applicant board must have a formal co-applicant agreement that stipulates: roles, responsibilities and the delegation of authorities; and any shared roles and responsibilities of each party in carrying out the governance functions.

²² As stated in PIN 1997-27, Affiliation Agreements of Community and Migrant Health Centers and/or PIN 1998-24, Amendment to PIN 1997-27, Regarding Affiliation Agreements of Community and Migrant Health Centers. Applicants are encouraged to review <http://bphc.hrsa.gov/about/requirements.html> for additional information on program requirements and expectations.

applicant has contracts for a substantial scope of project, the applicant must reference Form 8—Health Center Agreements throughout the response.

3. **Management Team.** Describe how the organization maintains a fully staffed management team (chief executive officer (CEO), chief clinical officer (CCO)/chief medical officer (CMO), chief financial officer (CFO), chief information officer (CIO), and chief operating officer (COO) as applicable), that is appropriate and adequate for the size, operational and oversight needs, and scope of the project and is in accordance with Health Center Program requirements. Explain any management positions that are combined and/or part time (e.g., CFO and COO roles are shared). Describe the organizational and management structure and lines of authority, referencing Attachment 9—Organizational Chart, as applicable. Provide position descriptions that include the associated roles, responsibilities, and qualifications and resumes for the CEO, CCO/CMO, CFO, CIO, and COO, referencing Attachment 10—Position Descriptions for Key Personnel, and Attachment 11—Resumes for Key Personnel, as applicable.
4. **Recruitment Plan.** Describe the plan for recruiting and retaining key management staff and health care providers as appropriate and discuss any key management staff changes in the last year, as applicable.
5. **Expertise with Target Population.** Describe expertise in working with the target population, including experience developing and implementing systems and services appropriate for addressing the target population’s identified primary health care needs.

NOTE: Public Housing Primary Care (PHPC) applicants must specifically describe how residents were involved in the development of the application and will be involved in administration of the project.

6. **Strategic Planning.** Describe the organization’s strategic planning process and how the target population’s health care needs and the related program evaluation objectives and data measures have been and will continue to be incorporated into ongoing strategic planning.
7. **Electronic Health Records (EHR).** Describe any current or planned acquisition/development and implementation of certified EHR technology systems used for tracking patient and clinical data to achieve meaningful use. More information about meaningful use is available at http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.
8. **Financial Information Systems.** Describe financial information systems that are in place for collecting, organizing, and tracking key performance data for program reporting on the organization's financial status (e.g., revenue generation by source, aged accounts receivable by income source, debt to equity ratio, net assets to expenses, working capital to expenses, visits by payor category) and that support management decision making.
9. **Collections and Reimbursement.** Describe systems that are in place to maximize collections and reimbursement for costs in providing health services, including written procedures for determining eligibility, as well as billing, credit, and collection policies and procedures.

10. **Financial Management.** Describe financial management capability, accounting and control systems, and policies and procedures appropriate for the size and complexity of the organization, and which reflect Generally Accepted Accounting Principles (GAAP). Describe how the organization maintains and separates functions appropriate to the organization's size to safeguard assets, maintain financial stability, and maintain a distinct scope of project for the look-alike designation and any other lines of business.
11. **Financial Audits.** Describe the organization's annual independent auditing process performed in accordance with Federal audit requirements. Provide the most recent financial audit (performed in accordance with Federal audit requirements), and the management letter in Attachment 13. Specific guidance for the submission of financial statements is in Appendix C: Required Attachments Instructions.
12. **Emergency Preparedness.** Discuss the status of emergency preparedness planning and development of emergency management plans, including participation or efforts to participate with State and local emergency planners. In addition, explain any "No" responses on Form 10—Annual Emergency Preparedness Report.²³
13. **Budget.** Describe how the budget is aligned and consistent with the service delivery plan and number of patients to be served.
14. **State Health Care Delivery Plan.** Describe current or proposed efforts to integrate with the state health care delivery plan for ensuring access to health care including outreach, enrollment, and delivery system reform.

Governance

NOTE: Applicants who are operated by Indian tribes or tribal, Indian or urban Indian groups should respond to ONLY Item 5 below²⁴ and should select N/A on Form 6B—Request for Waiver of Governance Requirements.

1. **Board Authority.** Discuss how the signed bylaws and/or other relevant documents demonstrate compliance with the Health Center Program requirements.²⁵ Specifically, describe how Attachment 3—Governing Board Bylaws, Attachment 6—Articles of Incorporation, and/or Attachment 4—Co-Applicant Agreement²⁶ document that the organization has an independent governing board that meets the following criteria:

²³ Review PIN 2007-15, Health Center Emergency Management Program Expectations, available at <http://bphc.hrsa.gov/policiesregulations/policies/pin200715expectations.html>.

²⁴ Per section 330(k)(3)(H) of the PHS Act Health Center Program governance requirements do not apply to health centers operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or urban Indian organizations under the Indian Health Care Improvement Act.

²⁵ Section 330(k)(3)(H) of the PHS Act and regulations at 42 CFR Part 51c304 or 42 CFR Part 56.304, as applicable.

²⁶ Public center applicants whose board cannot directly meet health center governance requirements are permitted to establish a separate co-applicant health center governing board that meets all the section 330 governance requirements. In the co-applicant arrangement, the public center receives the section 330 grant and

- a. Meets at least once a month;
 - b. Ensures that minutes are captured for all meetings;
 - c. Selects the services to be provided;
 - d. Determines the hours during which services will be provided;
 - e. Measures and evaluates the organization's progress in meeting its annual and long-term programmatic and financial goals and develops a plan for long-range viability;
 - f. Approves the health center's annual budget;
 - g. Approves the health center's look-alike applications;
 - h. Approves the selection/dismissal and conducts the annual performance evaluation of the organization's Executive Director/CEO;
 - i. Establishes general policies for the organization (only a public center may retain responsibility for establishing general fiscal and personnel policies); and
 - j. Establishes policies that include provisions that prohibit conflict of interest.
2. **Board Composition.** Document that the structure of the board (co-applicant board for a public center) is appropriate in terms of size (i.e., number of board members), composition, and expertise (e.g., board members have a broad range of skills and perspectives in areas such as finance, legal affairs, business, health, social services). More specifically, document that:
- a. The board is comprised of at least 51 percent of individuals who currently receive their primary health care from the organization (this requirement may be waived for eligible applicants; see Form 6B—Request for Waiver of Governance Requirements);
 - b. As a group, board members represent the individuals served by the organization in terms of race, ethnicity, and gender. Reference Form 4—Community Characteristics, and Form 6A—Current Board Member Characteristics;²⁷
 - c. Non-patient members are representative of the community in which the applicant's service area is located and are selected for their expertise;
 - d. Board has a minimum of nine but no more than 25 members, as appropriate for the complexity of the organization;
 - e. No more than half (50 percent) of the non-patient members derive more than 10 percent of their annual income from the health care industry; and
 - f. No board member is an employee of the health center or an immediate family member of an employee (only the CEO may serve as a non-voting, ex-officio board member).

NOTE: An applicant requesting designation to serve general community and special populations (Health Care for the Homeless, Migrant Health Center, and/or Public Housing Primary Care) must have appropriate board representation from both the general community and special populations. At minimum, there must be at least one representative from each of the special

the co-applicant board serves as the health center board. Together, the two are collectively referred to as the health center. The public center and health center board must have a formal co-applicant agreement that stipulates roles, responsibilities, and the delegation of authorities, including and any shared roles and responsibilities of each party in carrying out the governance functions for the health center.

²⁷ Eligible applicants requesting a waiver of the 51 percent patient majority board composition requirement must list the applicant's board members on Form 6A—Current Board Member Characteristics and NOT the members of any advisory council.

population groups for which designation is requested. Special population representatives should be individuals that can clearly communicate the needs/concerns of the target populations to the board (e.g., current resident of public housing, a formerly homeless individual, an advocate for migratory or seasonal agricultural workers).

3. **Board Operations.** Demonstrate the effectiveness of the governing board by describing how the board:
 - a. Operates, including the organization and responsibilities of board committees.
 - b. Monitors and evaluates its (the board's) performance.
 - c. Provides board training, development, and orientation for new members to ensure that they have sufficient knowledge to make informed decisions.
4. **Governance Waivers.** Applicants that are not designated under Community Health Center (section 330(e)) and have an approved waiver for the the 51 percents consumer/patient majority requirement must provide an update on the status of their alternative mechanism and discuss how the mechanism continues to meet the intent of the statute by ensuring consumer/patient representation.

NOTE: An approved waiver does not relieve the health center's governing body from fulfilling all other board authorities and responsibilities required by statute.

REQUIRED FORMS, DOCUMENTS, AND ATTACHMENTS

HRSA may disapprove applications that do not include all required forms, documents and attachments in accordance with the detailed instructions provided in Appendices A, B, and C.

Required Forms and Documents

Applicants must complete forms online using HRSA's EHB. Forms do not need to be downloaded or uploaded. Applicants create documents (e.g., Program Abstract and Program Narrative) and then upload them into the EHB system.

For detailed instructions for all forms, see Appendix A: Required Forms Instructions, Appendix B: Clinical and Financial Performance Measures Instructions and instructions as noted below. MS Word versions of all forms are available at <http://bphc.hrsa.gov/about/lookalike/index.html>.

REQUIRED FORMS OVERVIEW			
Required Documentation	Type	Description	Instructions
Cover Page (Required)	Form	Provides a summary of information related to the project at the time of application submission.	Appendix A
Form 1A—General Information Worksheet (Required)	Form	Provides a summary of information related to the applicant, service area, target population, provider information, and patient visits by service type.	Appendix A

REQUIRED FORMS OVERVIEW			
Required Documentation	Type	Description	Instructions
Project Abstract (Required)	Document	Provides a brief summary of the project.	Application Requirements, Project Abstract section (above)
Program Narrative (Required)	Document	Provides a comprehensive description of the project, including a detailed picture of the community/target population served, the organizational structure, and how the organization is addressing the identified primary health care needs of the community.	Application Requirements, Program Narrative section (above)
Clinical Performance Measures (Required)	Form	Provides time-framed and realistic goals and related clinical performance measures with baselines that are responsive to the identified primary health care needs of the community served and the strategic needs of the overall organization.	Appendix B
Financial Performance Measures (Required)	Form	Provides time-framed and realistic goals and related financial performance measures with baselines that are responsive to the identified financial needs of the community served and the strategic needs of the overall organization.	Appendix B
Form 2—Staffing Profile (Required)	Form	Reports personnel salaries supported by the total budget for the first year of designation period only. Current clinical staff must be described within the Program Narrative (6.a.).	Appendix A
Form 3—Income Analysis Form (Required)	Document	Projects program income, by source, for the first year of the designation period.	Appendix A
Form 3A—Look-Alike Budget Information (Required)	Form	Reports program budget by function and activity for the first year of the designation period.	Appendix A
Form 4—Community Characteristics (Required)	Form	Reports service area and target population data for the entire scope of the project for the most recent period for which data are available.	Appendix A
Form 5A—Services Provided (Required)	Form	Identifies what services are available and how these services are currently provided. This form will be pre-populated with the services in the current approved scope of project. No changes can be made.	Appendix A
Form 5B—Service Sites (Required)	Form	Identifies details of each service delivery site. This form will be pre-populated with the sites in the current approved scope of project. No changes can be made.	Appendix A

REQUIRED FORMS OVERVIEW			
Required Documentation	Type	Description	Instructions
Form 5C—Other Activities/Locations (as applicable)	Form	Provides information about activities/locations that: 1) do not meet the definition of a service site; 2) are conducted on an irregular timeframe/schedule; and/or 3) offer a limited activity from within the full complement of health center activities included within the Scope of Project. This form will be pre-populated with the other activities/locations in the current approved scope of project. No changes can be made.	Appendix A
Form 6A—Current Board Member Characteristics (Required)	Form	Provides information about governing board members, including areas of expertise and whether the member is a patient of the health center and/or a resident of the service area.	Appendix A
Form 6B—Request for Waiver of Governance Requirements (Required)	Form	Provides justification for and type of waiver requested. <i>Only organizations that request designation exclusively to serve a special population(s) authorized under section 330 of the PHS Act are eligible for a waiver of certain governance requirements.</i>	Appendix A
Form 8—Health Center Agreements (Required)	Form	Provides information about contracts and other agreements that constitute a substantial portion of the scope of project. <i>Form 8 is approved for the length of the designation period.</i>	Appendix A
Form 9—Need for Assistance (Required)	Form	Provides information about the need in the community specific to core barriers to primary care access, core health indicators, and other health indicators.	Appendix A
Form 10—Annual Emergency Preparedness and Management Report (Required)	Form	Provides information about the organization’s emergency preparedness planning and progress toward implementing an emergency management plan.	Appendix A
Form 12—Contact Information (Required)	Form	Identifies organizational contacts for ongoing communication with HRSA.	Appendix A

Required Attachments

Below is a brief overview of required attachments. Attachments are created by the applicant and are then uploaded to the EHB. ***For detailed instructions and requirements for Attachments, see Appendix C.***

Required Attachment	Description
Attachment 1—Service Area Map (Required)	Provides a map that clearly identifies the areas served by the organization, all service delivery sites, the designated MUA/MUP areas, census tracts, ZIP codes, and the location of other primary care provider sites (e.g., Health Center Program grantees, look-alikes, hospitals, free-clinics, etc.).
Attachment 2—Current or Requested MUA/MUP Designation (Required)	Provides documentation of the organization’s medically underserved area or population designation.
Attachment 3—Governing Board Bylaws (Required)	Describes the authorities and responsibilities of the governing board.
Attachment 4—Co-Applicant Agreement for Public Centers (as applicable)	Signed agreement between the public entity and co-applicant that describes how the two organizations will work together in support of the health center.
Attachment 5—Affiliation, Contract, and/or Referral Agreements (as applicable)	Provides a brief summary of current contracts and agreements (e.g., contracted provider and/or staff, management services contracts, formal referral arrangements, etc.).
Attachment 6—Articles of Incorporation (Required)	Provides official articles of incorporation, including seal page, documenting the State acceptance for the applicant of record.
Attachment 7—Evidence of Non-Profit or Public Agency Status (Required)	Provides official documentation of public entity or non-profit status.
Attachment 8—Medicare and Medicaid Provider Documentation (Required)	Provides evidence that the applicant is currently a primary health care Medicaid and Medicare provider.
Attachment 9—Organizational Chart (Required)	Provides a graphic depiction of the organizational and management structure and lines of authority, key employee position titles, names, and full-time equivalents.
Attachment 10—Position Descriptions for Key Personnel (Required)	Provides detailed information about each key personnel position.
Attachment 11—Resumes for Key Personnel (Required)	Provides resumes for all key personnel identified in the organizational chart.
Attachment 12—Schedule of Discounts/Sliding Fee Scale (Required)	Documents the organization’s sliding fee scale for patients under 200 percent of the most recent Federal poverty guidelines.
Attachment 13—Most Recent Independent Financial Audit (Required)	Provides the organization’s most recent independent financial audit and management letter.

Required Attachment	Description
Attachment 14—Letters of Support (Required)	Provides documentation of support for the organization’s look-alike designation from the other primary care providers in the area, including other Health Center Program grantees and look-alikes, rural health clinics, hospitals, state and local health departments, and other programs serving the same population(s).
Attachment 15—Floor Plans (as applicable)	Provides copies of floor plans for all sites within the scope of project, if new sites have been added during the current designation period. If an organization has had no change in the scope of the project, the organization does not need to provide floor plans unless there has been a change in layout of any site(s).
Attachment 16—Budget Narrative (Required)	Upload the Budget Justification in the Budget Narrative Attachment Form field.
Attachment 17—Other Information (as applicable)	Provides any additional information to support the application.

SUBMITTING THE APPLICATION

Applications must be submitted electronically through the HRSA Electronic Handbooks (EHBs). Refer to HRSA’s *Electronic Submission User Guide*, available online at <http://bphc.hrsa.gov/about/lookalike/index.html> for detailed application and submission instructions.

Renewal of designation applications are due 90 days prior to the end of the designation period. The EHB system will send electronic email reminders to the organization’s contacts identified in the EHB system 180 days prior to the end of the designation period to inform them the application is accessible in the EHB system. **Failure to submit the Renewal of Designation application could result in termination of the Look-Alike designation and all corresponding benefits (e.g., Medicare and Medicaid FQHC reimbursement, 340B Drug Pricing Program benefits, etc.).** Applicants can view Microsoft Word versions of all EHB forms at <http://bphc.hrsa.gov/about/lookalike/index.html>.

Once the Renewal of Designation application process is started in the EHB system, applicants have a maximum of 90 calendar days to complete and submit the entire application. Applications will be considered having been formally submitted if the application has been successfully transmitted electronically by the organization’s Authorizing Official (AO) through HRSA’s EHB within the 90 days following notification of the availability of the application in the HRSA EHB.

It is incumbent on the applicant to ensure that the AO is available to submit the application within the 90 day application period. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the 90 day application period. Therefore, applicants are urged to submit applications in advance of the 90 day deadline. If the application is rejected by HRSA’s EHB due to errors, the application must be corrected by the applicant and resubmitted to the EHB before the application deadline.

ADDITIONAL INFORMATION AND TECHNICAL ASSISTANCE

Program Requirements and Application Questions

Technical assistance regarding these instructions may be obtained by contacting the Project Officer assigned to your organization and/or the appropriate Primary Care Association (PCA), Primary Care Office (PCO), or National Cooperative Agreement (NCA). A list of these organizations is available at <http://bphc.hrsa.gov/technicalassistance/partnerlinks/index.html>.

Additional look-alike technical assistance is available at <http://bphc.hrsa.gov/about/lookalike/index.html>.

Navigating and Completing Applications in the EHB

For assistance with **navigating and completing BPHC applications in the EHB**, contact:

HRSA Bureau of Primary Health Care (BPHC) Helpline

Phone: 877-974-2742

Email: bphchelp@hrsa.gov

Hours of Operation: Monday – Friday, 8:30 AM to 5:30 PM ET

Appendix A: Required Forms Instructions

The BPHC Program Specific forms must be completed electronically in the HRSA EHB. To preview the forms, visit <http://bphc.hrsa.gov/about/lookalike/index.html>. Portions of the forms that are grayed out are not relevant to the application and do not need to be completed.

FORM 1A – General Information Worksheet (Required)

Form 1A provides a summary of information related to the look-alike project.

1. APPLICANT INFORMATION

- Complete all relevant information that is not pre-populated.
- Applicants may check only one category in the Business Entity section. If an applicant is a Tribal or Urban Indian entity and also meets the definition for a public or private entity, then the Applicant should select the Tribal or Urban Indian category.
- Applicants may select more than one category for the Organization Type section.

2. PROPOSED SERVICE AREA

2a. Target Population and Service Area Designation

- Applicants seeking section 330(e) look-alike designation for Community Health Centers (CHC) MUST provide Medically Underserved Area (MUA) and/or Medically Underserved Population (MUP) designation information. Select the MUA and/or MUP designations that best describe the service area. For inquiries regarding MUAs or MUPs, call 1-888-275-4772 (option 2) or contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816. For additional information, visit the Shortage Designation website at <http://bhpr.hrsa.gov/shortage>.
- Select the type of designation requested (i.e., section 330(e), section 330(g), section 330(h), and/or section 330(i)). Refer to definitions of the MHC, HCH, and PHPC populations.

2b. Service Area Type

- Classify the target population type as Urban, Rural, or Sparsely Populated. To be determined sparsely populated, the entire service area must have seven or fewer people per square mile.

2c. Target Population Information:

- Applicants with more than one site should report aggregate data for all of the sites included in the look-alike renewal of designation application.
- Provide the number of individuals currently composing the service area and target populations.

When providing the count of patients and visits, note the following guidelines (see the 2012 UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting> for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services must be documented in the patient's record. Such contacts provided by contractors and paid for by the grantee are considered to be visits.
- A patient is an individual who had at least one visit in the previous year.
- Since a patient must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits. Do not report patients and visits for services outside the

organization's scope of project. Specifically, the scope of project defines the service sites, services, providers, service area, and target population for which the look-alike designation applies. For more information, see PIN 2008-01 available at <http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html>.

- Do not report patients and visits for vision services.

Patients and Visits by Service Type:

- Project the number of patients and visits anticipated within each service type category across all look-alike sites by the end of the three-year designation period. Within each service type category (medical, dental, behavioral health, substance abuse, and enabling services), an individual can only be counted once as a patient. An individual who receives multiple types of services should be counted once for each service type (e.g., once for medical and once for dental).

Unduplicated Patients and Visits by Population Type:

- Project the number of patients and visits anticipated within each population type category across all look-alike sites.
- Data reported for patients and visits should not be duplicated within or across the four target population categories (i.e., General Community, Migratory and Seasonal Agricultural Workers, Public Housing Residents, People Experiencing Homelessness).

NOTE: The Population Type in this table refers to the population being served, not the designation Type (i.e., section 330(g), section 330(h), section 330(i)).

FORM 2 – Staffing Profile (Required)

The Staffing Profile reports personnel salaries supported by the total budget for the first year of the project. Include all staff directly employed by the health center (i.e., Form W-2, Wage and Tax Statement, issued by the health center).²⁸ Anticipated staff changes within the designation period must be addressed in the Resources/Capabilities section of the Program Narrative.

- Salaries in categories representing multiple positions (e.g., LPN, RN) must be averaged. To calculate the average annual salary, sum the salaries within the category and divide that amount by the total number of FTEs.
- Report ONLY portions of salaries that support activities within the look-alike scope of project.
- Do not include contracted (to include individual and organization level contracts) or volunteer staff on this form.

The Staffing Profile should be consistent with the personnel costs included in the budget justification.

²⁸ HRSA utilizes Internal Revenue Service (IRS) definition to differentiate employees and contractors. To be considered as an employee by the IRS, the individual must receive a salary from the covered entity on a regular basis with applicable taxes and benefits deducted along with coverage for unemployment compensation in most cases. The covered entity should issue a W-2 form for an employee to be a covered individual, and a Form 1099 to an individual who is a contractor.

FORM 3 – Income Analysis (Required)

Project the program income, by source, for the first year of the look-alike designation period by presenting the estimated revenues for the first year of the designation period. Anticipated changes within the designation period must be addressed in the budget justification. Entries that require additional explanation (e.g., projections that include reimbursement for billable events that UDS does not count as visits) must be discussed in the Comments/Explanatory Notes box and, if necessary, detailed in the budget justification. Form 3 must be based **ONLY** on the look-alike project.

The two major classifications of revenues are as follows.

PART 1: PROGRAM INCOME

The program income section groups billable visits and income into the same five payer groupings used in the Uniform Data System (UDS—see the UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics> for details). All patient service revenue is reported in this section of the form. This includes all income from medical, dental, behavioral health, substance abuse, other professional, vision, and other clinical services as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations which are designed to make up the difference between the approved FQHC rate and the interim amounts received. It includes risk pool and other incentive income as well as primary care case management fees.

Patient service revenue associated with sites or services not in the approved scope of project including those pending approval is to be excluded.

Column (a) Patients: These are the projected number of unduplicated patients classified by payer based upon the patient's **primary medical insurance**. The primary insurance is the payer that is billed first. The patients are classified in the same way as found in UDS Table 4, lines 7 – 12. This column should not include patients who are only seen for non-billable or enabling service visits. Examples for determining where to count patients include:

- A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Column (b): Billable Visits: These include all billable/reimbursable visits.²⁹ There may be other exclusions or additions which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (see [ancillary instructions](#) below).

²⁹ These visits will correspond closely with the visits reported on the UDS Table 5, excluding enabling service visits.

Column (c): Income per Visit: This is the quotient arrived at by dividing projected income by billable visits.

Column (d): Projected Income: This is the projected accrued net revenue, including an allowance for bad debt from all patient services for each pay grouping in the first year of the designation period.

Column (e): Prior FY Income Mo/Yr: This is the income data from the most recent fiscal year, which will be either interim statement data or audit data. The fiscal year was specified because the interim data can eventually be compared to actual audit data.

(Lines 1 – 5) Payer Categories: There are five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting the five payer groupings used in Table 9d of the UDS. The UDS instructions are to be used to define each payer category (see the UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics>).

Visits are reported on the line of the primary payer (payer billed first). The income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute that portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments to be paid by the patient, that income is to be shown on the self-pay line. If the co-payment is to be paid by another payer, that income should be shown on the other payer's line. It is acceptable if the applicant cannot accurately associate the income to secondary and subsequent sources.

All service income is to be classified by payer, including pharmacy and other ancillary service revenue. In the event the applicant does not normally classify the projected ancillary or other service revenue by payer category, the projected income is to be allocated by payer group using a reasonable allocation method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

(Line 1) Medicaid: This includes income from FQHC cost reimbursement; capitated managed care; fee-for-service managed care; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Children's Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap payments, incentives, and primary care case management income.

(Line 2) Medicare: This includes income from the FQHC cost reimbursement, capitated managed care, fee-for-service managed care, Medicare Advantage plans, and other reimbursement arrangements administered either directly by Medicare or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from the FQHC cost reimbursement, risk pool distributions, performance incentives, and care management fee income from the ACA Medicare Demonstration Program.

(Line 3) Other Public: This includes income from federal, state, or local government programs earned for providing services that is not reported elsewhere. A CHIP operated independently from the Medicaid

program is an example of other public insurance. Other public also includes income from categorical grant programs when the grant income is earned by providing services. Examples of these include CDC's National Breast and Cervical Cancer Early Detection Program and the Title X Family Planning Program.

(Line 4) Private: This includes income from private insurance plans, managed care plans, insurance plans from the ACA marketplaces/exchanges, and other private contracts for service. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers. Income from health benefit plans which are earned by government employees, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

(Line 5) Self-Pay: This includes income from patients, including full-pay self-pay and sliding fee patients, as well as the portion of the visit income for which an insured patient is personally responsible.

(Line 6) Total: This is the sum of lines 1-5.

PART 2: OTHER INCOME

This section includes all income other than the patient service revenue shown in Part 1. It includes other federal, state, local, and other income. It is income that is earned but not directly tied to providing visits, procedures, or other specific services. Income is to be classified on the lines below based upon the source from whom the revenue is received. Income from services provided to non-health center patients (patients of an entity with which the health center is contracting) either in-house or under contract with another entity such as a hospital, nursing home or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center. See Lines 9 and 10 for examples of services provided to non-health center patients (patients of an entity with which the health center is contracting).

(Line 7) Other Federal: This is income from federal grants where the look-alike organization is the recipient of a Notice of Award from a federal agency. It includes grants from federal sources such as the Centers for Disease Control (CDC), Housing and Urban Development (HUD), Centers for Medicaid and Medicare Services (CMS), and others.

(Line 8) State Government: This is income from state government grants, contracts, and programs, including uncompensated care grants; emergency preparedness grants; mortgage assistance; capital improvement grants; school health grants; Women, Infants, and Children (WIC); immunization grants; and similar awards.

(Line 9) Local Government: This is income from local government grants, contracts, and programs, including indigent care grants, community development block grants, capital improvement project grants, and similar awards. For example: (1) a health center that contracts with the local Department of Health to provide services to the Department's patients is to report all the income earned under this contract on this line, and (2) Ryan White Part A funds are federal funds awarded to municipalities who in

turn make awards to provider organizations, so Ryan White Part A grants would be classified as income earned from a local government and be shown on this line.

(Line 10) Private Grants/Contracts: This is income from private sources such foundations, non-profit entities, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, a health center operating a 340B pharmacy in part for its own patients and in part as a contractor to another health center is to report the pharmacy income for its own patients in Part 1 and the income from the contracted health center on this line.

(Line 11) Contributions: This is income from private entities and individual donors which may be the result of fund raising.

(Line 12) Other: This is incidental income not reported elsewhere and includes items such as interest income, patient record fees, vending machine income, dues, and rental income. Applicants typically have at least some Other income to report on Line 12.

(Line 13) Applicant (Retained Earnings): This is the amount of funds needed from the applicant's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why the applicant funds are needed and provide an assurance that the reserves are sufficient to meet the amount budgeted and that the remaining reserves are adequate to support normal operations.

(Line 14) Total Other: This is the sum of lines 7 – 13.

(Line 15) Total Non-Federal: This is the sum of Lines 6 and 14 and is the total non-federal income.

FORM 3A – Look-Alike Budget Information (Required)

Part 1: Expenses: includes personnel, fringe benefits, travel, equipment, supplies, contractual, construction, and other expenses. Indirect charges may also be included.

For each of the expense categories enter the projected upcoming year expenses for each of the applicable Programs, Functions, or Activities. If the categories in the form do not describe all possible expenses, organizations may enter expenses in the "Other" category. The total fields are calculated automatically as you move through the form.

Part 2: Revenue: includes funds supplied by the applicant and/or Federal, State, local, other sources. For each of the revenue categories, enter the projected upcoming year revenue from each of the applicable Programs, Functions, or Activities. If revenue is collected from sources other than the listed sources, indicate those in the "Other" category. The total fields are calculated automatically as you move through the form.

FORM 4 – Community Characteristics (Required)

Report service area and target population data for the entire scope of the project for which data are available (i.e., all look-alike sites). Race and ethnicity information will be used only to ensure compliance with statutory and regulatory governing board requirements.

Service area data must be specific to the project and include the total number of persons for each characteristic (percentages will automatically calculate in EHB). If information for the service area is not available, extrapolate data from the U.S. Census Bureau, local planning agencies, health departments, and other local, state, and national data sources. Estimates are acceptable.

Target population data is most often a subset of service area data. Report the number of persons for each characteristic (percentages will automatically calculate in EHB). ***Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.*** Estimates are acceptable.

If the target population includes a large number of transient individuals (e.g., the county has an influx of migratory and seasonal agricultural workers during the summer months) that are not included in the dataset used for service area data (e.g., census data), the applicant should adjust the service area numbers accordingly to ensure that the target population numbers are always less than or equal to the service area numbers.

*NOTE: The total numbers for the first four sections of this form (i.e., Race, Hispanic or Latino Identity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source) **must match**. These total numbers will also be consistent with the service area and target population totals reported on [Form 1A](#).*

Guidelines for Reporting Race

All individuals must be classified in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report. Utilize the following race definitions:

- Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
- Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Palau, Chuuk, Yap, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
- Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- More Than One Race – Persons who identify with 2 or more races.

Guidelines for Reporting Hispanic or Latino Identity

- If ethnicity is unknown, report individuals as Unreported/Declined to Report.
- Utilize the following ethnicity definition: Hispanic or Latino – Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

NOTE: Applicants compiling data from multiple data sources may find that the total numbers vary across sources. Such applicants should make adjustments as needed to ensure that the total numbers for the first four sections of this form match.

Guidelines for Reporting Special Populations

The Special Populations section of Form 4 does not have a row for total numbers; individuals that represent multiple special population categories should be counted in all applicable categories.

FORM 5A – Services Provided (Required)

Data will be pre-populated from the look-alike's official scope of project and **CANNOT** be modified. HRSA does not allow any change in scope or self-update at the time of the renewal of designation submission.

A look-alike's approved scope of project includes services on Form 5A. Services identified elsewhere in the application (e.g., Program Narrative) and not identified on Form 5A will not be considered to be in the approved scope of project.

NOTE: If your organization has a pending Change in Scope application to add a service, it will not be included in Form 5A until the Change in Scope has been approved and verified by applicant.

FORM 5B – Service Sites (Required)

Data will be pre-populated from the look-alike's official scope of project. No changes in scope or self-updates are allowed at the time of the renewal of designation submission.

A Look-Alike's approved scope of project includes service sites on Form 5B. Sites identified elsewhere in the application (e.g., Program Narrative) and not identified on Form 5B will not be considered to be in the approved scope of project.

FORM 5C – Other Activities/Location (As applicable)

Data will be pre-populated from the look-alike's official scope of project. The form is read-only and may not be modified. This form includes activities/locations that: 1) do not meet the definition of a service site; 2) are conducted on an irregular timeframe/schedule; and/or 3) offer a limited activity from within the full complement of health center activities included within the scope of project. Refer to PIN 2008-01, Defining Scope of Project and Policy for Requesting Changes (available at <http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html>) for more details.

HRSA will use the information presented on Form 5C to determine the scope of project for the look-alike. However, regardless of what information is included on Form 5C, only the services included on Form 5A and the service sites included on Form 5B will be considered part of the approved scope of project. Any additional activities/locations described or detailed in other portions of the application (e.g., narratives, attachments) that are not listed on Form 5C are not considered to be included in the approved scope of project.

FORM 6A – Current Board Member Characteristics (Required)

The data will be pre-populated from the previous annual certification, renewal of designation or initial designation submission. **Applicants are expected to update pre-populated information as appropriate.**

- Public entities with co-applicant health center governing boards must list the co-applicant board members.

- Applicants requesting a waiver of the 51 percent patient majority requirement must list the health center's board members, not the members of any advisory councils.
- List the current board office held for each board member, if applicable (e.g., Chair, Treasurer).
- List each board member's area of expertise (e.g., finance, teacher, nursing).
- Indicate if each board member is a health center patient.
- Indicate if each board member lives and/or works in the service area.
- List how long each individual has been on the board.
- Indicate if each board member is a representative of a special population (i.e., homeless, agricultural, public housing).
- Classify board members in terms of gender, ethnicity, and race.

NOTE: Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form. When Tribal is selected as the business entity on Form 1A, Form 6A will automatically display as complete. However, such applicants may include information on this form as desired.

FORM 8 – Health Center Agreements (Required)

Complete Part I, indicating whether current or agreements constitute a substantial portion of the scope of project. If the applicant has a contract for core primary care providers, non-provider health center staff, chief medical officer (CMO) or chief financial officer (CFO), if a site is operated by a contractor, which must also be identified in Form 5B—Service Sites, or if the applicant otherwise has an agreement to provide a substantial portion of the scope of project, the answer must be **“Yes.”** If **“Yes,”** indicate the number of each type in the appropriate field. If **“No,”** skip to the Governance Checklist in Part II.

Complete the Governance Checklist. If the response to any of the Governance Checklist items is **No**, the response to the question regarding agreements/arrangements affecting the governing board's composition, authorities, functions, or responsibilities must be **“Yes,”** and the number of such agreements/arrangements must be indicated. Additionally, **“No”** responses for the Governance Checklist must be explained in the Resources/Capabilities section of the Program Narrative.

Part III should be completed only by applicants that responded **“Yes”** to Part I.1 or Part II.2. In Part III, use the Organization Agreement Details section to provide the contact information for each organization (up to 10) with which an agreement/arrangement either (1) constitutes a substantial portion of the scope of project (as described in Part I) or (2) impacts the governing board's composition, authorities, functions, or responsibilities (as described in Part II). **Upload each agreement/arrangement** (up to 5) in full. Agreements/arrangements that exceed these limits should be included in Attachment 17—Other Information.

NOTE: Attachment 5—Affiliation, Contract and/or Referral Agreements must include a comprehensive list and summary of each arrangement, contract, and affiliation agreement, including those which are also discussed and attached in full as part of Form 8—Health Center Agreements.

FORM 9 – Need for Assistance Worksheet (NFA) (Required)

The worksheet is presented in three sections: Core Barriers, Core Health Indicators, and Other Health.

1. GENERAL INSTRUCTIONS FOR COMPLETING FORM 9

The worksheet is presented in three sections: Core Barriers, Core Health Indicators, and Other Health and Access Indicators.

Please note that the following changes have been made to the worksheet since the calendar year 2011/2012 renewal of designation application.

- Core Barrier: Percent of Population below 200 Percent Federal Poverty Level (FPL): Applicants are required to report the percentage of the **service area** population below 200 percent of the FPL. Only applicants applying to serve special populations exclusively (MHC, HCH, and/or PHPC) may use this barrier to report the percentage of the target population in poverty. See the [Data Reporting Guidelines Table](#) for additional clarification.
- Core Barrier: Percent of Population Uninsured: Applicants are required to report the percentage of the **service area** population that is uninsured. Only applicants applying to serve special populations exclusively (MHC, HCH, and/or PHPC) may use this barrier to report the percentage of the target population that is uninsured. See the [Data Reporting Guidelines Table](#) for additional clarification.
- Indicators in Section 2: Core Health Indicators and Section 3: Other Health and Access Indicators have been added, removed, or modified to include the most current indicators for which data are readily available at the sub-state level. In addition, corresponding benchmarks for each indicator have been updated.

Only one NFA Worksheet will be submitted per applicant. If an applicant proposes multiple sites, the NFA Worksheet responses should represent the total combined population for all sites. Data values for different sites should be combined. **Only one response may be submitted for each barrier or health indicator.**

Guidelines for Completing the NFA Worksheet

- All responses must be expressed as a finite number (e.g., 212.5) and cannot be presented as a range (e.g., 31-35).
- The data sources used should be those identified in the Data Resource Guide located at <http://www.hrsa.gov/grants/apply/assistance/sac> or alternative sources. Alternative sources must have the same parameters for each indicator as the source in the Data Resource Guide. For example, any source used for diabetes prevalence must provide age-adjusted rates. See the Data Resource Guide for more information.
- Responses to all indicators must be expressed in the same format/unit of analysis identified on the worksheet (e.g., a mortality ratio cannot be used to provide a response to age-adjusted death rate). The following table provides examples of the unit and format of responses.

Format/Unit of Analysis	Example Format	Example Description
Percent	25%	25 percent of target population is uninsured
Prevalence expressed	8.5%	8.5 percent of population has asthma

Format/Unit of Analysis	Example Format	Example Description
Prevalence expressed	9 per 1,000	9 of every 1,000 infants die
Rate	50 per 100,000	50 hospital admissions for hypertension per 100,000 population
Ratio	3,000:1	3,000 people per every 1 primary care physician

NOTE: When entering rate or ratio data in EHB, provide only the variable number, not the entire ratio (i.e., 3,000:1 would be entered as 3,000).

POPULATION BASIS FOR DATA

Provide data for three of four Core Barriers in Section 1, one Core Health Indicator for each of six categories in Section 2, and two of the 13 Other Health and Access Indicators in Section 3.

Data Reporting Guidelines Table

Applicants should report data for the NFA Worksheet measures based on the population groups specified in the table below. In cases where data are not available for the specific service area or target population, applicants are encouraged to explore the use of extrapolation techniques to make valid estimates using data available for related areas and population groups. See the Data Resource Guide located at <http://www.hrsa.gov/grants/apply/assistance/sac> for further information on the use of extrapolation. Where data are not directly available and extrapolation is not feasible, applicants should use the best available data describing the area or population to be served. In such a case, applicants must explain the data provided.

Form Sections	General Community 330(e) ONLY	General Community 330(e) plus one or more Special Populations (330(g), (h), and/or (i))	One or more Special Populations 330(g), (h), and/or (i) ONLY
Core Barrier: Population to One FTE Primary Care Physician	Target Population	Target Population	Target Population
Core Barrier: Percent of Population below 200% of Poverty	Service Area	Service Area	Target Population
Core Barrier: Percent of Population Uninsured	Service Area	Service Area	Target Population
Core Barrier: Distance (miles) or Travel Time (minutes) to Nearest Primary Care Provider Accepting New Medicaid and Uninsured Patients	N/A	N/A	N/A
Core Health Indicators	Target Population	Target Population	Target Population

Form Sections	General Community 330(e) ONLY	General Community 330(e) plus one or more Special Populations (330(g), (h), and/or (i))	One or more Special Populations 330(g), (h), and/or (i) ONLY
Other Health and Access Indicators	Target Population	Target Population	Target Population

NOTE: Core Barrier: Distance (miles) or Travel Time (minutes) to Nearest Primary Care Physician Accepting New Medicaid and Uninsured Patients is not calculated based on population. For this core barrier, distance/time is measured from the proposed site to the nearest physician accepting new Medicaid and uninsured patients.

Extrapolation

For detailed instructions for each indicator and information on using and documenting acceptable extrapolation techniques, refer to the Data Resource Guide (available at <http://www.hrsa.gov/grants/apply/assistance/sac>). Extrapolation to the service area, target population, or both may be needed. The need for extrapolation will depend on:

- Which Core Barrier or Health Indicator is being reported.
- Whether the applicant is targeting the entire population within the service area or a specific subset of the population.
- The availability and specificity of data for each Core Barrier and Health Indicator.

NOTE: Applicants must document how extrapolation was conducted and what data sources were used. The Data Resource Guide provides additional detail on using and documenting acceptable extrapolation techniques. If data are not available to conduct a valid extrapolation to the specific service area and/or target population, the applicant should use data pertaining to the immediately surrounding geographic area/population (e.g., if target population data are not available, service area data may be used; if county level data are available, state level data cannot be used).

DATA RESPONSE AND SOURCES

The Data Resource Guide provides a listing of recommended data sources and instructions on utilizing these sources to report each indicator. Applicants may use these sources or other alternate publicly available data sources if the data is collected and analyzed in the same way as the suggested data source. Applicants must use the following guidelines when reporting data:

- All data must be from a reliable and independent source, such as a state or local government agency, professional body, foundation, or other well-known organization using recognized, scientifically accepted data collection and/or analysis methods. Applicants must assure that any alternate sources used collect and report data in the same manner as the suggested data source.
- Applicants must provide the following information:
 - **Data Response**—The data reported for each indicator on which the NFA score will be based.
 - **Year to which Data Apply**—Provide the year of the data source. If the data apply to a period of more than one year, provide the most recent year for the data reported.
 - **Data Source/Description**—If a data source other than what is included in the Data Resource Guide is utilized, name the data source and provide a rationale (e.g., more current, more geographically specific, more population specific). For example, if a county-level survey

which meets all the required criteria was used, name that survey and provide a rationale for using it.

- **Methodology Utilized/Extrapolation Method**—Provide the following information:
 - Extrapolation methodology used—State whether extrapolation was from one geographic area to another, one population to another, both, or none.
 - Differentiating factor used—Describe the demographic factor upon which the extrapolation was based (e.g., rates by age, gender, race/ethnicity) and data source.
 - Level of geography—State geographic basis for the data (e.g., the data source may be a national survey, but the geographic basis for extrapolation was at the county level).
- **Identify Geographic Service Area or Target Population for Data**—Define the service area and/or target population used (e.g., zip codes, Census tracts, MUA or MUP designation, population type).

SECTION 1: CORE BARRIERS

A response is required for **3 of the 4 Core Barriers**. The table below provides the national median (50th percentile) benchmark for three of the four core barriers as a point of reference.

SECTION 1: CORE BARRIERS	National Median Benchmark
Population to One FTE Primary Care Physician	1,641
Percent of Population below 200% of Poverty	36.6%
Percent of Population Uninsured	14.1%
Distance or Travel Time to Nearest Primary Care Provider Accepting New Medicaid and Uninsured Patients	N/A

SECTION 2: CORE HEALTH INDICATORS

Applicant must provide a response to **1 core health indicator from each of the 6 categories**: Diabetes, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral Health. The table below provides the national median (50th percentile) benchmark for each indicator within the six categories as a point of reference.

If an applicant determines that none of the specified indicators represent the applicant’s service area or target population, the applicant may propose to use an “Other” alternative for that core health indicator category. In such a case, the National Median Benchmark field will display n/a. See the Data Resource Guide for detailed instructions on providing documentation for an “Other” indicator.

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark
1. Diabetes	
1(a) Age-adjusted diabetes prevalence	8.1%

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark
1(b) Adult obesity prevalence	27.6%
1(c) Age-adjusted diabetes mortality ³⁰ rate (per 100,000)	22.5
1(d) Percent of diabetic Medicare enrollees not receiving a hemoglobin A1c (HbA1c) test	18.0%
1(e) Percent of adults (18 years and older) with no physical activity in the past month	24.0%
1(f) Other	N/A
2. Cardiovascular Disease	
2(a) Hypertension hospital admission rate (18 years and older; per 100,000)	61.4
2(b) Congestive heart failure hospital admission rate (18 years and older; per 100,000)	361.7
2(c) Age-adjusted mortality from diseases of the heart ³¹ (per 100,000)	179.4
2(d) Proportion of adults reporting diagnosis of high blood pressure	28.7%
2(e) Percent of adults who have not had their blood cholesterol checked within the last 5 years	23.1%
2(f) Age-adjusted cerebrovascular disease mortality (per 100,000)	41.4
2(g) Other	N/A
3. Cancer	
3(a) Cancer screening – percent of women 18 years and older with no Pap test in past 3 years	18.4%
3(b) Cancer screening – percent of women 50 years and older with no mammogram in past 2 years	22.2%
3(c) Cancer screening – percent of adults 50 years and older with no fecal occult blood test (FOBT) within the past 2 years	83.3%
3(d) Percent of adults who currently smoke cigarettes	17.3%
3(e) Age-adjusted colorectal cancer mortality (per 100,000)	14.0
3(f) Age-adjusted breast cancer mortality (per 100,000) among females	22.1
3(g) Other	N/A
4. Prenatal and Perinatal Health	
4(a) Low birth weight (<2500 grams) rate (5 year average)	7.9%

³⁰ Number of deaths per 100,000 reported as due to diabetes as the underlying cause or as one of multiple causes of death (ICD-10 codes E10-E14).

³¹ Total number of deaths per 100,000 reported as due to heart disease (includes ICD-10 codes I00-I09, I11, I13, and I20-I51).

SECTION 2: CORE HEALTH INDICATOR CATEGORIES	National Median Benchmark
4(b) Infant mortality rate (5 year average; per 1,000)	6.6
4(c) Births to teenage mothers (ages 15-19; percent of all births)	8.4%
4(d) Late entry into prenatal care (entry after first trimester; percent of all births)	16.4%
4(e) Cigarette use during pregnancy (percent of all pregnancies)	14.1%
4(f) Percent of births that are preterm (<37 weeks gestational age)	12.0%
4(g) Other	N/A
5. Child Health	
5(a) Percent of children (19-35 months) not receiving recommended immunizations: 4-3-1-3-3-1-4 ³²	30.0%
5(b) Percent of children not tested for elevated blood lead levels by 72 months of age	84.1%
5(c) Pediatric asthma hospital admission rate (2-17 year olds; per 100,000)	116.0
5(d) Percent of children (10-17 years) who are obese	15%
5(e) Other	N/A
6. Behavioral Health	
6(a) Percent of adults with at least one major depressive episode in the past year	6.6%
6(b) Suicide rate (per 100,000)	13.5
6(c) Binge alcohol use in the past month (percent of population 12 years and older)	24.1%
6(d) Age-adjusted drug poisoning (i.e., overdose) mortality rate per 100,000 population	12.3
6(e) Other	N/A

SECTION 3: OTHER HEALTH AND ACCESS INDICATORS

Applicants must provide responses to **2 of the 13** Other Health and Access Indicators. The table below provides the national median (50th percentile) benchmark for each Other Health and Access Indicator as a point of reference.

SECTION 3: OTHER HEALTH AND ACCESS INDICATORS	National Median Benchmark
(a) Age-adjusted death rate (per 100,000)	764.8
(b) HIV infection prevalence	0.2%
(c) Percent elderly (65 and older)	15.2%

³² 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, 1 varicella, and 4 Pneumococcal conjugate.

SECTION 3: OTHER HEALTH AND ACCESS INDICATORS	National Median Benchmark
(d) Adult asthma hospital admission rate (18 years and older; per 100,000)	130.7
(e) Chronic Obstructive Pulmonary Disease hospital admission rate (18 years and older; per 100,000)	227.2
(f) Influenza and pneumonia death ³³ rate (3 year average; per 100,000)	18.6
(g) Adult current asthma prevalence	9.0%
(h) Age-adjusted unintentional injury deaths (per 100,000)	40.0
(i) Percent of population linguistically isolated (people 5 years and over who speak a language other than English at home)	10.3%
(j) Percent of adults (18+ years old) that could not see a doctor in the past year due to cost	13.4%
(k) Percentage of adults 65 years and older who have not had a flu shot in the past year	32.6%
(l) Chlamydia (sexually transmitted infection) rate (per 100,000)	389.5
(m) Percent of adults without a visit to a dentist or dental clinic in the past year for any reason	30.4%

Form 10 – Annual Emergency Preparedness Report (Required)

Select the appropriate responses regarding emergency preparedness. If any answer is no, explain the response in the Resources/Capabilities section of the Program Narrative. This form will be used to assess the status of emergency preparedness planning and progress towards developing and implementing an emergency management plan.

Form 12 – Organizational Contacts (Required)

Provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application.

³³ Three year average number of deaths per 100,000 due to influenza and pneumonia (ICD 10 codes J09-J18).

Appendix B: Clinical and Financial Performance Measures Instructions

The clinical and financial performance measures serve as ongoing monitoring and evaluation tools for look-alikes and HRSA. The performance measures should include time-framed and realistic goals for related performance measures (as referenced below) with baselines that are responsive to the identified primary health care needs of the community served and the strategic needs of the overall organization, including multiple sites and/or various activities at multiple sites. If baselines are not yet available, identify when the data will be available. Look-alikes must develop new goals and baselines for each renewal of designation application.

Performance Measures

Applicants must respond to the health center performance measures within each Need/Focus Area identified below, as appropriate. The health center performance measures are accessible on HRSA's website at <http://bphc.hrsa.gov/policiesregulations/performance Measures/>. Additional information on the Clinical Performance Measures can be found in the annual Uniform Data System Reporting Manual available at <http://bphc.hrsa.gov/uds/>. Additional technical assistance related to the clinical and financial performance measures is available through HRSA and the State PCA.

- Applicants are required to report prenatal and perinatal performance measures. Please refer to Program Assistance Letter 2013-07 located at <http://bphc.hrsa.gov/policiesregulations/policies/pal201307.html>. Applicants reporting these measures for the first time can enter 0 for the baseline data and provide a date by which baseline data will be gathered. The projected data field must be completed with a predicted three-year goal (estimates are acceptable).

If the applicant is applying for look-alike designation to target special populations (i.e., migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing), **must include** additional performance measures that address the health care needs of these populations. In providing additional performance measures specific to a special population, applicants must reference the target group in the performance measure. For example, if an applicant seeks funds to serve migratory and seasonal agricultural workers, then the applicant must propose to measure *“the percentage of migratory and seasonal agricultural workers who...”* **rather than** simply *“the percentage of patients who...”*.

- If the applicant has identified other unique issues (e.g., populations, age groups, health issues, risk management efforts) in the Need section of the Program Narrative, they are encouraged to include additional related performance measures.
- All performance measures must include a numerator and denominator that can be tracked over time.
- Any additional narrative regarding the clinical and financial performance measures should be included in the Evaluative Measures section of the Program Narrative, as appropriate.

Special Instructions for Existing Performance Measures

Report the **Diabetes Clinical Performance Measure** as follows:

- Report adult patients with HbA1c levels ≤ 9 percent in the Baseline Data (numerator and denominator subfields) and Projected Data fields.
- If desired, report the additional measurement thresholds (i.e., < 7 percent, < 8 percent, > 9 percent) in the Comments field.

The **Child Health Performance Measure** has been modified to include the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate vaccines by age 3.

The **Cancer Screening Performance Measure** has been modified to include the following: Number of female patients age 24 - 64 years of age who received one or more documented Pap tests during the measurement year or during the two years prior to the measurement year OR, for women over 30, received a Pap test accompanied with an HPV test done during the measurement year or the four years prior who had at least one medical visit during the reporting year.

Applicants must address the performance measures provided by HRSA, as applicable. All applicants must also include one Behavioral Health (e.g., Mental Health or Substance Abuse) and one Oral Health performance measure of their choice in the clinical performance measures.

Applicants may also wish to consider utilizing Healthy People 2020 goals and performance measures when developing their clinical and financial performance measures. Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The program consists of 41 focus areas and more than 1,400 objectives. Further information on Healthy People 2020 goals may be downloaded at <http://www.healthypeople.gov/document/>.

Need Addressed/Focus Area

This is a concise categorization of the major need or focus area to be addressed by the applicant for their service area, target population, and/or organization (Diabetes; Cardiovascular; Costs, Productivity; etc.). Applicants are expected to address each required performance measurement area as well as any other key needs of their target population or organization as identified in the application narrative.

Designation Period Goal(s) with Baseline

Goals relating to the Need/Focus Area should be listed in this section. Applicants should provide goals for the required performance measures listed above as well as other goals, which can be accomplished by the end of the designation period (usually a three-year period). The goals should be reasonable, measurable, and reflect an anticipated impact upon the specified need or focus area. The applicant must also provide baseline data to indicate their status at or prior to the beginning of the designation period. Baseline data provides a basis for quantifying the amount of progress/improvement to be accomplished in the designation period. If applicants choose to establish a baseline for any of the new clinical performance measures, they are encouraged to utilize current data. Applicants are expected to track performance against these goals throughout the entire approved designation period and to report interim progress achieved on the goal in subsequent Annual Certification applications.

Performance Measure(s)

Applicants must make use of the required performance measures listed above when setting goals in the Designation Period Goal(s) with Baseline section (also noted in the sample performance measures). Applicants may also include additional performance measures. Additional measures chosen by the applicant should also define the numerator and denominator that will be used to determine the level of progress/improvement achieved on each goal (e.g., Numerator: One or more screenings for colorectal cancer. Denominator: All patients age 51-80 years during the measurement year).

Data Source & Methodology

The source of performance measure data, method of collection and analysis (e.g., electronic health records, disease registries, chart audits/sampling) should be noted by the applicant. Data should be valid and reliable and derived from currently established management information systems, where possible.

Key Factors

This is a brief description of the key factors (up to 3) that may impact (positively or negatively) the applicant's progress on each of the clinical and financial performance measures.

Major Planned Actions

This is a brief description of the major planned actions (up to 2) to be completed in response to the key factors identified in the Key Factors section impacting performance on the clinical and financial performance measures.

Comments/Notes

Supplementary information, notes, context for related entries in the plan may be provided, as applicable.

SAMPLE MEASURES

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE		FOR HRSA USE ONLY	
		Organization Name	Application Tracking Number
		XYZ Health Center	00000
		Designation Period Date	01/01/2014 - 12/31/2017
Focus Area: Diabetes			
Performance Measure: Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent			
Is this Performance Measure Applicable to your Organization?	Yes		
Target Goal Description	By the end of the Designation Period, increase the % of adult patients with type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is ≤ 9% (under control) up to 65%		
Numerator Description	Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.		
Denominator Description	Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria		
Baseline Data	Baseline Year: 2013 Measure Type: Percentage Numerator: 2200 Denominator: 4000	Projected Data (by End of Designation Period)	65%
Data Source & Methodology	Representative sample of patient records. (Data run on 1/10/2010)		
Key Factor and Major Planned Action #1	Key Factor Type: <input checked="" type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: XYZ offers a variety of pharmaceutical assistance programs, including the provision of free, discounted, or generic medications as well as medications through its 340B Federal Drug Pricing arrangement. At least 70% of diabetic patients are on 3 to 8 medications because of co-morbidity complications that occur. Major Planned Action Description: Increase education and outreach efforts to diabetic patients on the importance of daily testing and the availability of free/discounted glucometers and test strips available through XYZ.		
Key Factor and Major Planned Action #2	Key Factor Type: <input checked="" type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: XYZ has an agency-wide, multidisciplinary team that includes physicians, nurses, medical assistants, a quality management coordinator and a data specialist. The team works with each site to analyze and improve the internal processes to achieve effective diabetes care delivery. Major Planned Action Description: At each site, XYZ will identify a physician champion who will be allotted administrative time to work with fellow staff to test and implement changes. The agency-wide and site-specific teams will form a collaborative infrastructure that provides diabetic patients with the necessary tools and support to successfully manage their disease.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE		FOR HRSA USE ONLY	
		Organization Name	Application Tracking Number
		XYZ Health Center	00000
		Designation Period Date	01/01/2014 - 12/31/2017
Key Factor and Major Planned Action #3	Key Factor Type: <input type="checkbox"/> Contributing <input checked="" type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: Time management becomes problematic when XYZ staff juggles regular work with Diabetes Collaborative tasks. The agency-wide team would like to meet more frequently, but providers are pressed for administrative time given their full clinical schedules. Any type of backlog or deficiency adds system stress to a provider or staff member's work schedule that negatively affects patient care management. Major Planned Action Description: Hire an additional clinical staff person to provide additional "non-clinical" review time for the agency-wide team members.		
Comments			

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE FINANCIAL PERFORMANCE MEASURE	FOR HRSA USE ONLY				
	Organization Name		Application Tracking Number		
	XYZ		00001		
	Designation Period Date		01/01/2014 - 12/31/2017		
Focus Area: Costs					
Performance Measure: Medical Cost per Medical Visit					
Is this Performance Measure Applicable to your Organization?					
Target Goal Description	By the end of the Designation Period, maintain rate of increase not exceeding 5% per year, such that medical cost per medical visit is less than or equal to 164.83.				
Numerator Description	Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray costs)				
Denominator Description	Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits)				
Baseline Data	Baseline Year: 2013 Measure Type: Ratio Numerator: 492000 Denominator: 4000	Projected Data (by End of Designation Period)	164.83		
Data Source & Methodology	UDS				
Key Factor and Major Planned Action #1	Key Factor Type: <input checked="" type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: Recent addition of nurse practitioner providers increased XYZ encounters. Major Planned Action Description: Continue assessing current patient/provider mix to best utilize resources.				
Key Factor and Major Planned Action #2	Key Factor Type: <input type="checkbox"/> Contributing <input checked="" type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: Recently lost our pediatrician to a local competitor, therefore child visits are down. Major Planned Action Description: We are beginning efforts to recruit a NHSC loan repayer to address the shortage.				
Key Factor and Major Planned Action #3	Key Factor Type: <input type="checkbox"/> Contributing <input type="checkbox"/> Restricting <input type="checkbox"/> Not Applicable Key Factor Description: Major Planned Action Description:				
Comments					

Appendix C: Required Attachments Instructions

To ensure that attachments are organized and printed in a consistent manner, follow the order provided below.

- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment).
- Merge similar documents (e.g., Letters of Support) into a single document. Add a table of contents page specific to the attachment.
- Limit file names for attachments to 100 characters or less. Attachments will be rejected by EHB if file names exceed 100 characters.
- If the attachments marked “required for completeness” are not uploaded, the application will be considered incomplete and non-responsive, thereby making it ineligible.

Attachment 1—Service Area Map (Required)

Maps should be created using HRSA’s UDS Mapper located at <http://www.udsmapper.org>. Upload a map of the service area for the project which clearly identifies:

1. The areas (e.g., zip codes or census tracts) served by the organization.
2. Each service delivery site listed in Form 5B--Service Sites.
3. Designated medically underserved areas (MUAs) and/or medically underserved populations (MUPs).
4. All Health Center Program grantees in the service area.
5. All Health Center Program look-alikes in the service area.
6. Other health care providers serving the same population(s), e.g., free clinics, rural health centers, etc.
7. The UDS data that complements the information provided in the map.

Please note: You will have to manually place markers for the locations of other major private provider groups serving low income/uninsured populations.

Include a corresponding table that lists each zip code tabulation area (ZCTA) in the service area, the number of Health Center Program grantees serving each ZCTA, the dominant grantee serving the ZCTA and its share of Health Center Program patients, total population, total low-income population, total Health Center Program grantee patients, and patient penetration levels for each ZCTA and for the overall proposed service area. This table will be automatically created in UDS Mapper when the map is created. See <http://www.hrsa.gov/grants/apply/assistance/sac> for samples and instructions on creating maps using UDS Mapper. For a tutorial on how to create a map, see How To’s: Create a Service Area Map and Data Table at <http://www.udsmapper.org/tutorials.cfm>.

Attachment 2— Current MUA/MUP Designation (Required)

Provide a dated copy of the current MUA/MUP designation. For inquiries regarding MUA/MUP, call 1-888-275-4772 (press option 1, then option 2); contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816; or obtain additional information at <http://bhpr.hrsa.gov/shortage/>. Applicants may submit as documentation of the MUA/MUP designation a confirmation page from HRSA’s “Find Shortage Areas” website.

Attachment 3—Governing Board Bylaws (Required)

Provide a signed and dated copy of the governing board bylaws. The bylaws must demonstrate compliance with the board authority, composition, conflict of interest and all other requirements of section 330 of the PHS Act, 42 CFR 51c, and 42 CFR 56 (as applicable).

Attachment 4—Co-Applicant Agreement for Public Centers (As applicable)

Public centers (also referred to as public entities or public agencies) with a co-applicant arrangement must provide a signed and dated copy of the written agreement between the two parties. The co-applicant agreement must identify the roles and responsibilities of both the public center and co-applicant, the delegation of authorities of both parties, and any shared roles and responsibilities in carrying out the governance functions.

Attachment 5—Affiliation, Contract, and/or Referral Agreements (As applicable)

Provide one document that includes a summary of each affiliation, contract or agreement (e.g., contracted providers, staff, management services, and formal referral arrangements).

Attachment 5—Affiliation, Contract and/or Referral Agreements must include a comprehensive list and summary of each arrangement, contract, and affiliation agreement, including those which are also discussed and attached in full as part of Form 8—Health Center Agreements. Indicate with an asterisk (*) agreements in Attachment 5 that are also attached in full as part of Form 8.

Applicants that do not have contractual agreements with another entity should clearly indicate so in the narrative. As a reminder, contracts must be in compliance with section 330 of the PHS Act and 42 CFR Part 51c.

Organize each summary by the following categories.

Formal Written Contracts/Agreements for Services Provided

Summaries of formal written contracts/agreements for required services (i.e., services indicated in Form 5A—Services Provided, Column II) must include:

1. Name and contact information for each provider or provider group.
2. Brief description of the purpose and scope of each contract, including the type of services to be provided, how and where services will be provided, how the service will be documented in the patient record; how the applicant will pay and/or bill for the service; and how the applicant's policies and procedures, including the applicability of a sliding fee scale, will apply.
3. Timeframe for each agreement/contract.

Formal Written Referral Arrangements/Agreements for Services Provided

Summaries of formal written referral arrangements/agreements (i.e., services indicated in Form 5A—Services Provided, Column III) must include:

1. Name and contact information for each affiliated agency or provider.
2. Brief description of the purpose and scope of each arrangement/agreement, including, type of services to be provided, the manner by which the referral will be made and managed, how and where services will be provided.

3. How services will be provided on a sliding fee scale compliant with Health Center Program requirements.
4. How the referred visit will be documented in the patient record.
5. How continuity of care for the referred patients will be assured, to include a description of the process for referring patients back to the applicant for appropriate follow-up care.

Other Contracts and Affiliation Agreements

Summaries of other contracts (i.e., contracts or affiliations for management and other services not included on Form 5A—Services Provided) must include:

1. Name and contact information for each affiliated agency or provider.
2. Brief description of the purpose and scope of each contract/affiliation, including the type of services to be provided, how and where services will be provided, and how the health center will reimburse costs.
3. Timeframe for each contract/affiliation.

NOTE: All affiliation, contract, and referral agreements must be available for submission to HRSA by request.

NOTE: In Form 8—Health Center Agreements, applicants must note and attach in full all contracts that make up a substantial scope of project, e.g., contracting for core primary care providers, non-provider health center staff, chief medical officer (CMO) or chief financial officer (CFO), if a site is operated by a contractor, or if the applicant has an agreement that otherwise constitutes a substantial portion of the scope of project. These agreements must also be summarized in Attachment 5—Affiliation, Contract and/or Referral Agreements.

Attachment 6—Articles of Incorporation (Required)

Private, non-profit organizations must provide a copy of the Articles of Incorporation filed with the State or other evidence of non-profit status (e.g., a letter from the State or the Federal government or evidence that an application for non-profit status has been submitted). Include the seal page documenting the State acceptance of the articles.

Attachment 7—Evidence of Non-Profit or Public Agency Status (Required)

Private Nonprofit: A private, nonprofit organization must submit any one of the following as evidence of its nonprofit status:

- A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- A statement from a state taxing body, state Attorney General, or other appropriate state official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- Any of the above proof for a state or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

Public Center: Consistent with PIN 2010-10

<http://bphc.hrsa.gov/policiesregulations/policies/pin201001.html>), applicants must provide documentation demonstrating that the organization qualifies as a public entity (e.g., health department, university health system) for the purposes of section 330 of the PHS Act, as amended. Any of the following is acceptable:

1. Affirm Instrumentality Letter (4076C) from the IRS or a letter of authority from the Federal, state, or local government granting the entity one or more sovereign powers.
2. A determination letter issued by the IRS providing evidence of a past positive ruling by the IRS or other documentation demonstrating that the organization is an instrumentality of government, such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state controls the organization.

Formal documentation from a sovereign state's taxing authority equivalent to the IRS granting the entity one or more governmental powers. Public entity applicants can refer to PIN 2010-01, Confirming Public Agency Status under the Health Center Program and look-alike Program, located at <http://bphc.hrsa.gov/policiesregulations/policies/pin201001.html>.

Attachment 8—Medicare and Medicaid Provider Documentation (Required)

Submit a copy of CMS notification that documents the organization is an approved primary care Medicare and Medicaid provider and the provider numbers.

Attachment 9—Organizational Chart (Required)

Provide an organizational chart showing the organizational and management structure, and lines of authority. The chart must include:

- Key employee position titles;
- Names; and
- Full-time equivalents (FTEs) of each individual. Provide a justification for any part-time or split positions in the Program Narrative.

Clearly identify each individual with the following responsibilities:

- CEO/Executive Director
- Chief Medical Officer (CMO)/Clinical Director;
- Chief Financial Officer (CFO)/Financial Manager; and
- Other key management staff, e.g., Chief Operations Officer (COO).

The chart should demonstrate that the governing board retains ultimate authority and leadership of the organization.

Public entities with co-applicant arrangements should demonstrate the relationship between the two co-applicants and the co-applicants' relationships to the health center.

Attachment 10—Position Descriptions for Key Personnel (Required)

Submit a copy of position descriptions for all key management positions. Indicate if key management positions are combined and/or part-time (e.g., chief financial officer (CFO) and chief operation officer (COO) roles are shared). At minimum, position descriptions should include:

- Position title
- Description of duties and responsibilities
- Position qualifications, supervisory relationships
- Skills, knowledge and experience requirements
- Travel requirements
- Salary range
- Hours worked

Attachment 11—Resumes for Key Personnel (Required)

Provide resumes of key personnel for the organization. If a resume is included for an identified individual who is not yet hired, include a letter of commitment from that person along with the resume.

Attachment 12—Schedule of Discounts/Sliding Fee Scale (Required)

Provide a schedule of charges with a corresponding schedule of discounts for which charges are adjusted on the basis of the patient's ability to pay. Applicants must show sliding fee scale discounts for persons with incomes between 200 percent and 100 percent of the most current annual Federal poverty guidelines (see the most current annual poverty guidelines at <http://aspe.hhs.gov/poverty/>). Patients with incomes below 100 percent of the Federal poverty guidelines may not be charged for services (nominal fees are acceptable if they are not barriers to obtaining services). No discounts may be given to patients with incomes over 200 percent of the Federal poverty guidelines.

Attachment 13—Most Recent Independent Financial Audit (Required)

Submit a complete copy of the organization's most recent annual audit, including the auditor's opinion statement (i.e., management letter). Audit information must include the balance sheet, profit and loss statement, audit findings, and any noted exceptions. The audit must comply with generally accepted accounting principles (GAAP).

Attachment 14—Letters of Support (Required)

Submit current and dated letters of support addressed to the appropriate organization contact (e.g., board, CEO) to document commitment to the request for look-alike renewal of designation from the other primary care providers in or adjacent to the service area, including FQHCs (i.e., each Health Center Program grantee and look-alike), rural health clinics, hospitals, local health departments, and other programs serving the same population(s). If one or more letters from other local providers serving the same population are not provided, provide an explanation in the Program Narrative and upload evidence of requesting such support in Attachment 17 as appropriate. See the Collaboration section of the Project Narrative for more details on required collaboration.

Attachment 15—Floor Plans (As applicable)

Submit floor plans for all operational look-alike sites if there has been a change in service sites during the current designation period or if there has been any changes to the layout of floor plans at any site(s).

Attachment 16—Budget Narrative (Required)

A detailed budget justification in line-item format must be provided for **each 12-month period**. A 3-year budget justification is required. **An itemization of revenues and expenses is necessary only for the first year of the budget justification.** Attach the budget justification in the Budget Narrative Attachment

Form section in EHB. The budget justification must be concise and should not be used to expand the Program Narrative. Please be aware that Excel or other spreadsheet documents with multiple pages (sheets) may not print out in their entirety.

Attachment 17—Other Information (As applicable)

Include other relevant documents to support the project plan.